

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

July 20, 2017

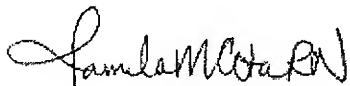
Ms. Helen Bishop, Manager  
Our House At Park Terrace  
48 South Main Street  
Rutland, VT 05701-4163

Dear Ms. Bishop:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 31, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief



PRINTED: 06/13/2017  
FORM APPROVED

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R100	Initial Comments:  An unannounced re-licensing survey was conducted by the Division of Licensing and Protection from 5/30/17 - 5/31/17 to determine compliance with the Residential Care Home Licensing Regulations. The following regulatory violations were identified:	R100			
R104 SS=A	V. RESIDENT CARE AND HOME SERVICES  5.1 Admission  5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy.  (1) In addition to general resident agreement requirements, agreements for all ACCS	R104	<i>R104 Oversight - this administrator is to blame - Agreement has been completed with the R+B figure added - manager will monitor for accuracy.</i>	5/31/17	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6809

V4PK11

If continuation sheet 1 of 10

R104 - R314 POCs accepted 7/20/17 Pmcintosh/RL/pmc

PRINTED: 06/13/2017  
FORM APPROVED

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R104	Continued From page 1  participants shall include: the ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment.  This REQUIREMENT is not met as evidenced by: Based on record review, the admission agreement for Resident # 2 failed to include the monthly rate the resident would be charged upon admission to the Residential Care Home (RCH). (Resident #2) Findings include:  During the review of the record for Resident #2, the admission agreement failed to reflect the monthly charge the resident would be responsible for while living at the residence. The owner/manager stated on the afternoon of 5/30/17 s/he was unaware a monthly rate had not been included in the signed admission agreement.	R104		
R107 SS=A	V. RESIDENT CARE AND HOME SERVICES  5.2 Admission  5.2.a  (4) If the home agrees to accept SSI or ACCS payments and allows the resident to remain in the home when the resident's financial status changes, the home must provide the resident with a new admission agreement as provided to all ACCS participants.	R107  R107	New agreement was sent to Guardian but no follow up - Gdn will be in to sign ACCS/ERC agreements on 6/29/17 manager will monitor for compliance.	6/29/17

PRINTED: 06/13/2017  
FORM APPROVED

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R107	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on record review, the RCH failed to provide 1 of 12 residents with a new admission agreement when the Resident's financial status changed after the Resident transitioned from private pay to a new payer source. (Resident # 3) Findings include:  Per record review, Resident #3 was admitted to the RCH on 1/7/16. At the time of admission the resident paid room and board privately. The resident has now transition to a new reimbursement source for room and board, however a new agreement has not been created to identify the change and what the new monthly charges would include.	R107		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.9.c (2)  Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the RCH failed to assure the Plan of Care reflected the current care needs and interventions for 1 of 4 residents in the total sample. (Resident #2) Findings include:	R145	<i>R145</i> Resident #2 written Behavior Plan discusses "inappropriate" behaviors but does NOT specify due to the nature of this residents personality and challenges - Also was discharged from RCH with a cleared psych eval that he was NOT a danger to himself or others - but will add to careplan.	
		<i>R145</i>	Careplan was updated per Survey Findings - RN and Manager will review Careplans for accuracy monthly or when changes occur.	6/2/17

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R145	Continued From page 3  Per record review, Resident #2 has a past history of depression and suicidal ideation and required a crisis evaluation in April 2017, after being brought to the Emergency Department for a intentional ingestion of a food source known to cause the resident an allergic reaction. The resident also requires close monitoring for unsolicited and overly attentive behaviors toward residents residing in the RCH. This behavior was observed during the 2 days of survey. The plan of care does not address either of these issues or provide direction to staff to be attentive to any targeting behaviors or voicing expressions of suicidal ideation. Per interview on the afternoon of 5/30/17 the house manager and nurse confirmed an awareness of the resident's observed behavior and attentiveness with certain residents. The nurse further acknowledge on the afternoon of 5/31/17 the Plan of Care failed to address the concerns and provide further direction for staff.	R145			
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES  5.11 Staff Services  5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the Residential Care Home (RCH) failed to assure there was sufficient number of qualified staff at all times to provide necessary care, to	R178  R178	Scheduler has been made aware of Surveyors concerns and is working on additional staffing - Caregivers are aware of calling for backup when necessary - As residents change so do Staffing Patterns - House manager		

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R178	<p>Continued From page 4</p> <p>maintain a safe environment, and to assure prompt, appropriate action to meet resident needs. (Resident #1 &amp; #2) Findings include:</p> <p>1. Per observations made during the course of the 2 day survey on 5/30/17 &amp; 5/31/17, it was apparent sufficient staff was necessary to assure ongoing monitoring of 2 residents with behavioral issues and 4 residents requiring assistance with Activities of Daily Living (ADLs) to include transfers, mobility, toileting and dressing. In addition, staff are assigned responsibility for administering medications, preparing meals, house keeping (laundry, bed making, cleaning) completing documentation and maintaining a safe setting for all residents.</p> <p>Per record review, Resident #1 has a history since admission in 12/2016 of wandering in resident rooms, interrupting residents when using the bathroom, waking them at night and invading residents' personal space. During such incidents, record review noted some residents have become angry and frustrated with the resident's behaviors and the possibility for retaliation was evident. Observations on 5/30/17 noted staff constantly redirecting Resident #1 throughout the day, repeating answers to repetitive questions from the resident and interrupting staff responsibilities to include providing the care and services to other residents in need of assistance with ambulation, toileting, medication administration, meal preparation and provision of ongoing daily care for all residents.</p> <p>Additional observations on 5/30/17 included Resident #2 approaching on 3 separate occasions a resident with moderate impaired cognition. During each episode Resident #2, with no cognition impairment, sat close to the resident</p>	R178 <i>Cont'd</i>	<p>and Scheduler are always Communicating about Needs and will make Sure to fill voids when necessary -</p> <p>manager to monitor and Communicate Needs to Scheduler as needed.</p> <p>Video surveillance Cameras are on and recording 24/7 for quality assurance.</p> <p>In addition the A.M. Shift has been extended to 2:30 which adds coverage through Shift Change.</p>	<p>7/7/17</p> <p>7/24/17</p>

PRINTED: 06/13/2017  
FORM APPROVED

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R178	<p>Continued From page 5</p> <p>and made comments which were inappropriate and disrespectful. Per record review, Resident #2 has in the recent past made provocative statements to other residents and requires redirection and monitoring. Per the "Written Behavior Plan" RCH staff are to instruct the resident to stop behaviors and separate herself/himself for quiet time.</p> <p>However, per review of RCH staff schedule, only 1 staff member is scheduled from 6:00 AM to 8:00 AM, a time period when at least 4 residents, some with recent history of falls, may require assistance with ADLs, mobility and toileting and other residents require queuing/ monitoring. Additional tasks include breakfast preparation along with managing administration of PRN (as needed) medications. From 2:00 PM to 4:30 PM and again from 8:30 PM to 10:00 PM only 1 staff is available to complete evening tasks to include preparing residents for bed, managing and queuing residents, monitoring behaviors, housekeeping responsibilities and PRN medication administration. The present RCH staffing schedule fails to assure there is consistent number of staff available at all times to provide necessary care, maintain a safe and healthy environment by assuring staff can act promptly and respond to behavioral issues, resident to resident altercations, a possible resident injury, illness or other potential emergencies involving the residence. Staff confirmed the schedule provided was accurate and reflected specific times of the day and evening when only one staff member was scheduled, during other times on day and evening there are 2 staff members present.</p>	R178			

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
R249	Continued From page 6	R249		
R249 SS=E	VII. NUTRITION AND FOOD SERVICES  7.2 Food Safety and Sanitation  7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, a RCH staff member failed to maintain safe food handling practice during the preparation of drinks for residents during the noon time meal. Findings include:  During observations of the noon meal on 5/30/17 & 5/31/17 an RCH staff member used bare hands and without the use a serving utensil removed ice cubes from a freezer container and placed ice cubes in drinking glasses for the residents in preparation for the noon meal. Per interview on the afternoon of 5/31/17, the owner/manager agreed the staff member should wear gloves and/or use a utensil to serve ice.	R249		
R277 SS=C	IX. PHYSICAL PLANT  9.3 Toilet, Bathing and Lavatory Facilities  9.3.a Toilet, lavatories and bathing areas shall be equipped with grab bars for the safety of the residents. There shall be at least one (1) full bathroom that meets the requirements of the Americans with Disabilities Act of 1990 and state building accessibility requirements as enforced by the Department of Labor and Industry.	R277		



PRINTED: 06/13/2017  
FORM APPROVED

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETE DATE
R277	Continued From page 7  This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the half bathroom on the first floor was not equipped with grab bars. Finding includes:  A half bathroom located in a back hallway was observed being utilized by both staff and residents. Observation of the bathroom noted grab bars have not been installed. The house manager confirmed the observation on the afternoon of 5/31/17.	R277			
R281 SS=C	IX. PHYSICAL PLANT  9.3 Toilet, Bathing and Lavatory Facilities  9.3.e Resident lavatories and toilets shall not be used as utility rooms.  This REQUIREMENT is not met as evidenced by: Based on observation, a bathroom used by residents is also used as a utility room. Findings include:  During the 2 days of survey, the half bathroom on the first floor used by both staff and residents also had stored within the bathroom a large mop bucket and mop. In addition, other miscellaneous supplies were also noted to be stored in the bathroom.	R281  R281	Provider does NOT agree with the Surveyors interpretation of regulation HOWEVER A Cabinet to store mop + Bucket has been ordered to be used as soon as it arrives for all supplies. Caregivers will be advised and manager will monitor for compliance.		7/3/17
R313 SS=C	XI. RESIDENT FUNDS AND PROPERTY  11.1 A resident's money and other valuables	R313  R313	Provider does NOT agree with interpretation of regulation - Safe keeping was initiated many years ago for just		

PRINTED: 06/13/2017  
FORM APPROVED

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R313	Continued From page 8  shall be in the control of the resident, except where there is a guardian, attorney in fact (power of attorney), or representative payee who requests otherwise. The home may manage the resident's finances only upon the written request of the resident. There shall be a written agreement stating the assistance requested, the terms of same, the funds or property and persons involved.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH failed to obtain a signed written request from either the resident or the resident's legal guardian, Power of Attorney (POA), or representative payee to manage money held by the RCH for 6 applicable residents. (Residents # 1, 2, 3, 4, 5, 6, ) Findings:  Per observation, the RCH is actively holding various amounts of money for 6 residents, which are dispersed to the residents upon their request. The RCH failed to obtain a signed written request by either the resident or resident's legal guardian, POA or representative payee. The RCH house manager confirmed no signed written requests have been obtained.	R313	That - we do NOT manage any residents finances However due to interpretation there will no longer be any money allowed in the home unless residents choose to keep it on their person. all families are being advised and money will be removed from safe keeping - Administrator and managers will monitor for accuracy.		7/3/17
R314 SS=C	XI. RESIDENT FUNDS AND PROPERTY  11.2 If the home manages the resident's finances, the home must keep a record of all transactions, provide the resident with a quarterly statement, and keep all resident funds separate from the home or licensee's funds  This REQUIREMENT is not met as evidenced	R314	SEE 313		7/3/17

PRINTED: 06/13/2017  
FORM APPROVED

## Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  05/31/2017
NAME OF PROVIDER OR SUPPLIER  OUR HOUSE AT PARK TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 48 SOUTH MAIN STREET RUTLAND, VT 05701			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R314	Continued From page 9  by: Based on staff interview and record review, the RCH failed to provide a quarterly statement of money held for 7 residents. (Resident #1, 2, 3, 4, 5, 6, ). Findings include:  Although the RCH manages a separate internal accounting of each of the 6 resident funds, there was a failure to provide either the resident and/or the resident's representative, guardian, POA or representative payee a quarterly accounting of money deposited and/or withdrawals and reason for withdrawal of funds held by the RCH. This was confirmed on the afternoon of 5/31/17 by the RCH house manager.	R314			